PUBLIC HEALTH, WELFARE & SAFETY

Exhibit No. 8

Date 2-7-07

Bill No. SB 312

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Testimony on SB 312
Before the Senate Public Health, Welfare and Safety Committee

By Bob Olsen, Vice President, MHA
February 8, 2007

The proponents of SB 312 argue that hospitals are using their economic clout to pressure, limit or otherwise control physicians' ability to practice medicine. This simply isn't true.

This bill arises because the business world of health care has changed drastically in the past few years. In today's health care world, hospitals and physicians alike are trying to navigate an increasingly complex web of business and insurance arrangements.

It's not uncommon for physicians to compete directly with not-for-profit, community hospitals. This competition comes from physician-owned, for-profit surgery centers, specialty clinics, imaging centers and other facilities.

And, it can be argued, this ownership interest gives physicians an incentive to refer patients to their facility.

Yet, these same physicians also often want privileges to practice at the local non-profit, community-based hospital.

When a physician wishes to both practice at the hospital and compete with the hospital, that physician has a conflict of interest.

Enactment of SB 312 says hospitals can no longer adopt measures that recognize legitimate conflicts of interest and establish policies that address these conflicts of interest.

Federal Rules Govern Hospital Boards and Medical Staffs

Federal Medicare rules impose the responsibility for the conduct of a non-profit, community hospital on the facility's Board of Directors.

Under these federal rules, the board's responsibilities include addressing the operations of the hospital, appointing the members of the medical staff and ensuring that the hospital fulfills its mission. (A copy of the federal interpretive guidelines is attached to my testimony.)

Federal rules also require that a hospital has a medical staff. The medical staff must be governed by bylaws and procedures for processing applications from physicians who would like to join the medical staff and establishing the medical staff's accountability for the quality of care provided at the hospital.

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These bylaws also are designed to ensure that medical treatment is provided in accordance with the orders of the practitioner and that the provider is working within the scope of his or her privilege.

The federal guidelines direct hospital boards to base their evaluation and selection of medical staff on the recommendation of the existing medical staff and a physician's individual character, competence training, experience and judgment.

When a physician disagrees with the recommendations of the medical staff, there is an appeal procedure provided to address those concerns.

SB 312 would drastically change the way hospital governance would occur. It would make the staff at the Department of Public Health and Human Services the arbiter in cases where there is a dispute over credentialing between a physician and a hospital.

It would insert the state into what has traditionally been a matter determined by federal rules, a hospital's medical staff and a hospital's board. In our view, state regulation is simply not needed in this area.

Conflicts of Interest

As I said at the outset of my testimony, this situation has arisen because hospitals are attempting to navigate an increasingly complex web of physician business arrangements – business arrangements that often put physicians in financial conflict with the hospital in which they hold privileges.

The lawyers say a conflict of interest exists when there is a divergence between an individual's private interests and the interests of the hospital such that an independent observer might reasonably question whether the individual's actions or decisions affecting the hospital or patients might be substantially influenced by those private interests.

The lawyers also define a conflict of interest as a direct or indirect financial interest of the individual or his or her spouse, siblings or children in an entity that competes with the hospital in the provision of any patient care services.

MHA does not consider hospital-sponsored joint ventures to be a conflict of interest, because they support the hospital's mission of providing care to its patients.

Because conflicts of interest do not, in and of themselves, reflect upon the professional qualifications or clinical competence of medical staff members, they are appropriately addressed by a Board of Directors policy, rather than by the disciplinary procedures of the medical staff.

The lawyers say that, at a minimum, no physician who holds a financial interest in a facility that competes directly with the hospital should hold a legal right or other claim to be placed in a medical staff leadership position, hospital governance position or have access to non-public information.

A hospital could choose to allow a physician with a conflict of interest to participate in such a role. A hospital could allow that physician to participate in medical staff leadership, but with the caveat that the physician be excused from any discussion of proprietary information and not be allowed to vote on certain matters that come before the medical staff.

Finally, a hospital that determines that the physician's conflict of interest, and subsequent actions caused by that conflict, impairs the mission of the hospital should be able to terminate the physician's privileges.

To illustrate the issues that are raised here, the following is excerpted from an affidavit shared with MHA pertaining to a person who was referred out-of-network for medical care (details that protect the physician and patient identity are removed):

> "The patient is under my care for an injury. The patient underwent surgical treatment....I requested that the patient have surgery at the ambulatory surgical center. I am on the medical staff at the surgery center. I am also on the staff of the local hospital. The hospital is a provider for the patient's insurance plan, while the surgical center is not. I requested that the surgery be performed at the surgery center because the hospital performs very few of these procedures, their equipment has become out-of-date and is inferior to the surgical center. I do not feel that the hospital equipment is up to the standard of care in this area presently."

This statement is not meant to indict the physician. Rather, it demonstrates the conflict a physician with an equity interest in a competing health care facility faces when deciding where to refer the patient for care.

But there's more to this story...because the physician, by being a member of both medical staffs is also in a position to influence the type of equipment each provider purchases and the service volumes that each provider attains.

Since the physician controls the referral of patients for care, he or she also heavily influences the delivery of care, and as such, the ability of the provider to continue to deliver certain services.

Finally, the physician with an ownership interest in a competing facility may also be accused of "cherry picking" insured patients who require services for which a provider is well-reimbursed, while leaving the uninsured or indigent patients who require care for which providers aren't adequately reimbursed to the community hospitals.

Conclusion

SB 312 would take away a hospital's right to address these conflicts of interest. By doing so, SB 312 could make it impossible for a nonprofit, community hospital to fulfill its mission.

For these reasons, we urge the committee to reject SB 312.

§482.12 Condition of Participation: Governing Body

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

Interpretive Guidelines §482.12

The hospital must have only one governing body and this governing body is responsible for the conduct of the hospital as an institution. In the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are responsible for the conduct of the hospital operations.

§482.12(a) Standard: Medical Staff

The governing body must:

§482.12(a)(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

Interpretive Guidelines §482.12(a)(1)

The governing body must determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

§482.12(a)(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;

Interpretive Guidelines §482.12(a)(2)

It is the responsibility of the governing body to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering existing medical staff members recommendations, and in accordance with established hospital medical staff criteria and State and Federal laws and regulations, the governing body appoints new members or reappoints current members to the medical staff.

§482.12(a)(3) Assure that the medical staff has bylaws;

Interpretive Guidelines §482.12(a)(3)

The governing body must assure that the medical staff has bylaws and that those bylaws comply with State and Federal law and the requirements of the Medicare hospital Conditions of Participation.

§482.12(a)(4) Approve medical staff bylaws and other medical staff rules and regulations;

Interpretive Guidelines §482.12(a)(4)

The governing body decides whether or not to approve medical staff bylaws submitted by the medical staff. The medical staff bylaws and any revisions must be approved by the governing body before they are considered effective.

§482.12(a)(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;

Interpretive Guidelines §482.12(a)(5)

The governing body must ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. The governing body is responsible for the conduct of the hospital and this conduct includes the quality of care provided to patients.

All hospital patients must be under the care of a member of the medical staff or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner who meets the medical staff criteria and procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the governing body, and who is working within the scope of those granted privileges.

§482.12(a)(6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and

Interpretive Guidelines §482.12(a)(6)

The governing body ensures that the criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on:

- Individual character;
- Individual competence;
- Individual training;
- Individual experience; and
- Individual judgment.

§482.12(a)(7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.

Interpretive Guidelines §482.12(a)(7)

The governing body must ensure that the hospital's rules and criteria for medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.

A hospital is not prohibited from requiring board certification when considering a MD/DO for medical staff membership. Rather, the regulation provides that a hospital may not rely solely on the fact that a MD/DO is

or is not board certified in making a judgment on medical staff membership. In addition to matters of board certification, a hospital must also consider other criteria such as training, character, competence and judgment. After analysis of all of the criteria, if all criteria are met except for board certification, the hospital has the discretion to decide not to select that individual to the medical staff.

§482.12(b) Standard: Chief Executive Officer
State Operations Provider Certification Manual (CMS-Pub. 100-07)
§482.12(b) Standard: Chief Executive Officer

The governing body must appoint a chief executive officer who is responsible for managing the hospital.

Interpretive Guidelines §482.12(b)

The Governing Body must appoint one chief executive officer who is responsible for managing the entire hospital.